

Fifty Years of PULHHEEMS—The British Army's System of Medical Classification

To the Editor:

The development of the British Army's system of medical classification illustrates concepts that are very relevant to modern occupational health. In 1939,¹ there was a mobilisation for war of the United Kingdom's reserve forces. These soldiers were placed in a number of medical categories as follow:

- A – fit for general service at home and abroad,
- B – unfit for general service abroad but fit for base or garrison service at home and abroad,
- C – fit for home service only,
- D – unfit for any form of military service.

The situation was complicated by the need to examine all civilian recruits, both volunteers and those called up to the Army. These examinations were performed by Civilian Medical Boards which classified recruits into four grades, the fourth being unfit for service.

These grades only took account of the physical and medical condition of the recruit and made neither allowance for where the recruit was to be sent nor for their employment. Not surprisingly, there were complaints that recruits were physically incapable of performing their duties.

What was needed was a system that translated the four grades given by the Civilian Medical Boards into something of use to the Army. This was critical because it was essential to ensure the economical use of manpower. In 1940, a system of categories was selected by the Army as follows:

- A1, A2, B1, B2, B3, B4, B5: These seven categories were based on vision in relation to shooting and driving, physical endurance, the ability to march and the manifestation of any other disease which would affect military duty. The categories also had caveats which determined both task and location worldwide.
- C: Home service only.
- D: Temporarily unfit.
- E: Permanently unfit.

The Army allocated a soldier to one of these categories on the basis of the Civilian Medical Board grades. The linkage was complex and never worked well.

The scale of the problem is worth noting.² During the Second World War, it is calculated that the Civilian Medical Boards undertook over seven million examinations, taking more than three and a half million hours. The results of the

examinations show that by the age of 37, only 44% were fit for their age and 20% were unfit for service.

During the War, this classification system evolved but it was never entirely satisfactory. By 1945, there were some 72 sub-categories. The key problem was the failure by medical officers, when assessing physical capacity, to distinguish between the mere existence of defect and what result that defect had on functional ability.

Various developments were introduced. These included the re-examination of recruits after one month in training and the re-examination of personnel who had been categorised as unfit for duty, before they were sent back to duty. Various geographical qualifications were also included to ensure that soldiers, who were basically fit but could not go to the tropics, were employed in their highest category.

The unsatisfactory situation resulted in the adoption of a Canadian system, known as PULHEMS. The PULHEMS acronym stands for the following qualities:

P – physical capacity, U – upper extremity, L – locomotion, H – hearing, E – eyesight, M – mental capacity, S – stability of emotions.

For each quality, the soldier is given a number. From this, a PULHHEEMS profile, a series of numbers, is derived. Note that an extra H and an extra E have been introduced so that each ear and eye can be assessed separately. This profile is used to place soldiers in an appropriate employment by the use of PULHHEEMS Employment Standards which provide a linkage to the type of work carried out by each part of the Army and includes geographical restrictions.

The following is a simplification of the current British Army's PULHHEEMS System, which has developed over 50 years:

P2 – fully fit, P3 – light duties, P3R – pregnant, P7 – limited duties, P8 – medically unfit, P0 – unfit, under medical care.

The P quality for overall physical capacity is the dominant one. Recent developments have concluded that the geographical limitations were unnecessarily restrictive and more flexibility has been introduced.

The history of the introduction and development of the PULHHEEMS System has been evolutionary. It has proved remarkably robust. Since the end of the Cold War and with the development of a more expeditionary army, there has been a need to simplify it. Underpinning the system is the

need to link medical conditions appropriately to the work done.

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